STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____ and _____

have terminated our domestic partner relationship effective _____.

I understand that health, dental and vision coverage for the covered domestic partner named above and their dependent(s) will terminate on the first of the month following the below listed execution date.

I understand that another Affidavit for Enrollment of Domestic Partners cannot be filed until six months from the date of the filing of this statement.

I declare under penalty of perjury that the above statements are true and correct.

_____	_____	_____
Name of Employee	Signature of Employee	Employee ID No.
_____	_____	_____
Name of Domestic Partner	Signature of Domestic Partner	Employee ID No. (If Applicable)

_____
Date of Completion

Please complete and return to Human Resources – Benefits Division by fax to 858-467-9708 or by email to: DHRBenefits.FGG@sdcounty.ca.gov
Please retain a copy for your records.